(Figure 1) very useful in documenting the clinical findings at each consultation. This 'checklist' not only guides the clinical examination based on presenting symptoms but also helps proper documentation—a vital part of defending the clinical decisions at a later date (especially if medico-legal issues arise). We place a lot of emphasis on reviewing the patient at regular intervals for at least 18 months and have a very low threshold for neuroimaging should the symptoms worsen during the review period.

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Sir,
Optic disc and peripheral neovascularization in a young male

Case report

An 8-year-old Asian male presented to his optometrist for a routine review.

On examination, his visual acuity was 6/6 in both the eyes, anterior segments, intra-ocular pressures, and vitreous were normal. Bilateral disc and peripheral neovascularization was evident with peripheral retinal ischaemia and ghost vessels (Figure 1). The patient was born full term in the

United Kingdom, and had mild childhood asthma and hayfever. Systemic assessment was normal and there was no family history. Fluorescein angiography confirmed the presence of bilateral disc and peripheral neovascularization with extensive areas of midperipheral capillary nonperfusion, without branch retinal vein or arterial occlusion. No delay in choroidal or retinal vessel filling was observed. Chest X-ray, Mantoux test, fasting blood glucose, ESR, CRP, serum ACE, sickle cell, ANA, anti-dsDNA antibodies, syphilis serology, anti-phospholipid antibodies, activated partial prothrombin time, prothrombin time, fibrinogen level, Protein C, and Protein S were all normal.

The patient was diagnosed with Eales' disease even though the clinical presentation was unusual for Eales' disease given the young age, and presence of both optic disc and peripheral retinal neovascularization. The patient was treated with bilateral panretinal photocoagulation under general anaesthesia. At 6 weeks postphotocoagulation the vision in the left eye dropped to hand movements following a pre-retinal haemorrhage. The patient underwent a left three-port pars plana vitrectomy with further laser panretinal photocoagulation. The neovascularization regressed, and was replaced with glial tissue (Figure 1). At 2 years after treatment, his condition remains stable and visual acuity 6/6 in both eyes.

Comment

Eales' disease is an idiopathic obliterative vasculopathy that is uncommon in the UK. The condition most commonly occurs in healthy adult males aged between 20 and 30 years, and the youngest case reported is in a 10-year-old.^{1–3} To our knowledge, our 8-year-old patient is the youngest reported case of Eales' disease.

Eales' disease progresses through several stages periphlebitis, perivasculitis, neovascularization, vitreous haemorrhage, and tractional retinal detachment. Although the aetiology of Eales' disease is unknown, hypersensitivity to infectious agents, such as tuberculosis and autoimmunity have been proposed.¹ The treatment of Eales' disease requires the exclusion of systemic illness, and laser panretinal photocoagulation.⁴ Vitreous haemorrhage may commonly occur and without treatment tractional retinal detachment result.^{5–7} Prognosis is poor with delayed treatment, and in our patient prompt Argon laser photocoagulation and early vitrectomy following

Figure 1 Photographs showing bilateral optic disc neovascularization, and peripheral ischaemia and neovascularization in the right eye.

vitreous haemorrhage, resulting in an excellent visual outcome.

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Sir, Intravitreal triamcinolone as a primary therapy in diabetic macular oedema

Karacorlu *et al*'s article on the use of intravitreal triamcinolone in patients with diabetic macular oedema and no previous laser treatment suggested that there was some beneficial effect in the short term.¹ However, we would like to highlight several points that may affect the conclusions of their study.

Firstly, the medical history of the 12 patients in their study was not disclosed. There was no mention of known risk factors for diabetic maculopathy such as type and duration of diabetes, hypertension, nephropathy, and smoking. It is well recognised that good control of hypertension and serum glucose levels can improve diabetic macular oedema.^{2,3} The improvement in the oedema and visual acuity reported in some of the patients could be attributed to concurrent improvement in their other systemic medical problems.

Eligibility criteria included persistent macular oedema despite medical treatment with topical corticosteroids, topical nonsteroidal anti-inflammatory drugs, and systemic acetazolamide. To our knowledge, diabetic macular oedema is not usually treated with any of these medications, which are normally used for cystoid macular oedema (CMO) following cataract surgery. Additionally, the angiographic definition for diabetic